ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

The provider agrees to the following provisions for submitting Medicare claims electronically to HCFA or to HCFA's contractors.

A. The Provider Agrees:

1. That it will be responsible for all Medicare claims submitted to HCFA by itself, its employees, or its agents.

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except HCFA and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.

3. That it will submit claims only on behalf of those Medicare beneficiaries who have given their written authorization to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file.

4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
    - Beneficiary's name,
    - Beneficiary's health insurance claim number,
    - Date(s) of service,
    - Diagnosis/nature of illness, and
    - Procedure/service performed

5. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the Social Security Act, Federal regulations, and HCFA guidelines.

6. That it will ensure that all claims for Medicare primary payment have been developed for other insurance involvement and that Medicare is the primary payer.

7. That it will submit claims that are accurate, complete, and truthful.

8. That it will retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least 6 years, 3 months after the bill is paid.

9. That it will affix the HCFA-assigned unique identifier number of the provider on each claim electronically transmitted to the contractor.

10. That the HCFA-assigned unique identifier number constitutes the provider's legal electronic signature and constitutes an assurance by the provider that services were performed as billed.

11. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law.

13. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from HCFA or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with § 1106(a) of the Act).

14. That it will research and correct claim discrepancies.

15. That it will notify the contractor or HCFA within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Health Care Financing Administration Agrees To:

1. Transmit to the provider an acknowledgement of claim receipt.

2. Affix the intermediary/carrier number, as its electronic signature, on each remittance advice sent to the provider.

3. Ensure that payments to providers are timely in accordance with HCFA's policies.

4. Ensure that no contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic billers have equal access to any services that HCFA requires Medicare contractors to make available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:
Federal law should govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by HCFA under this document.

This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to HCFA or the contractor.

Either party may terminate this agreement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

NSC Medicare Supplier Number _____ NJ PAAD/Medicaid RX Number _____

Provider's Legal Name _____ Provider's DBA Name _____

Address _____ City/State/Zip _____

( ) _____ ( ) _____ _____
Phone Number Fax Number E-mail Address

Signature and Title _____ Date _____

Billing Service: New Jersey Department of Health and Senior Services, PAAD
PO Box 715, Trenton, NJ 08625-0715
609-588-7146
Submitter #A08008700

Authorization for the above billing service applies only to claims that are dually eligible for Medicare and PAAD.